
SAICOHEALTH
DAMANA
MEMBER
GUIDEBOOK
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CONTENT

INTRODUCTION

Your insurance policy comprises of the list of benefits, medical card, hospital network and other documents related to our services including the contract we have with your Employer.

This guidebook is designed to set out the key features and benefits of your Healthcare Plan. It includes general terms, conditions, definitions, general exclusions, frequently asked questions and complaints handling procedures for your plan.

If you have any questions about the information in the guidebook, please contact us using our contacts printed at the backside of your medical card and we will be more than happy to help you.

Some words and phrases used in this guidebook, your list of benefits and your claims procedures have specific meanings. We have defined them in the 'Definitions' section.

Please take few moments to read about your plan. We look forward to providing you with the highest standards of service. You can rest assured that we are there to support you.

IMPORTANT INFORMATION ABOUT YOUR PLAN

Member's Eligibility

Our plans are available to the eligible employees and their dependents (when applicable)

The eligible members for our plans must be:

- a sponsored employee(s) of the insured company
- a spouse(s) of the employee(s) residing in the same country
- dependent children under 18 years old, unmarried and residing with the employee in the same country
- the employees and their dependents will have the same benefits and coverage

Adding or Deleting your Dependents

Your employer can ask to add your eligible family members to your policy at any time during the term of the policy. All material facts about your dependent should be disclosed to us including any medical condition or treatment that is planned.

Please note the following:

- Your dependents must be added to the same plan you are enrolled in
- No backdate for the cover under any circumstance
- Any addition to a policy must be supported by valid and supporting documents as requested by us, i.e.: new entry permit, current visa, birth certificate, etc… This is subject to the applicable rules and regulations in the local jurisdiction where the policy is issued
- Once the addition is agreed and processed, we will send your employer the medical cards for each of your dependents
- Refer to your HR for any mandatory documents or data required for addition and termination based on the rules and regulations of your country of residency

Leaving the Plan

Your request for deletion should be sent to us via your employer. The deletion request will only be processed upon receipt of the supporting documents.

Please note the following:

- If you are removed from a plan, the deletion date will be the date that we receive the request with all supporting documents, or a future date, which was requested by your employer and given to us
- If an employee is removed from a plan, all the dependents under the employee will also be removed
- If you wish to remove a dependent, please contact your employer
- When you or your dependents leave any plan, you must return the medical cards to your employer

DEFINITIONS

Terms	Definitions
Benefit	*Services covered and excluded under the medical insurance plan.*
Chronic disease	*A disease requiring regular, uninterrupted, long-term/life time treatments or if the diagnosed illness persist for long duration, i.e.: > 6 months.*
Co-Insurance	*The defined monetary amount, in addition to the deductible, which covered persons are required to pay for certain health services provided under the policy. Covered persons are responsible for the payment of any co-payment for network and non-network benefits directly to the provider of the health service at the time of service or when billed by the provider.* *This co-insurance amount may also be deducted at the times of settlement of any reimbursement claim made by the covered persons.*
Cosmetic	*Services, procedures or items that are supplied only for aesthetic purposes and which are not needed in order to maintain an acceptable standard of health.*
Daycare treatment	*A Health Service or medical treatment that must be provided in the hospital or supervised medical facility, but it does not require an overnight stay in the hospital.*
Deductible	*An amount that must be incurred and paid for by the covered person before benefits are payable under this policy. This amount is payable by the covered person per each outpatient consultation and this amount is stated in the schedule of benefits.*
Dependent	◗ *Employee's spouse, whose name has been provided to insurer prior to the commencement of any treatment.* ◗ *Unmarried children under 19 years of age and 24 years covered if children are in full time education and fully dependent on primary insured and residing at the same residence as the primary insured at the commencement of any treatment unless local applicable law would require otherwise.*
Designated healthcare providers/network providers	*A group of healthcare providers contracted by SAICOHEALTH for the purpose of providing access to their health services on a direct billing basis in conformity with the terms of this policy.*
Effective date	*The date cover starts for the employee and their dependents.*

Terms	Definitions
Emergency	*Emergency services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunctions of any bodily organ or part*
Eligible employee	*Any staff member who is working, nominated and sponsored by the client who becomes a member of the plan.*
Experimental, investigational or unproven services	*Medical, surgical, diagnostic, or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the company makes a determination regarding coverage in a particular case, is determined to be:* ◗ *subject to formal review and approval by local medical authorities for the proposed use; or* ◗ *subject of an ongoing clinical trial* ◗ *not demonstrated through prevailing pre-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.* *The Company, in its judgment, may deem an experimental, investigational or unproven service to be a covered health service for treating a life threatening sickness or condition if it is determined by the company that the experimental, investigational or unproven service at the time of the determination:* ◗ *is safe with promising efficacy; and* ◗ *is provided in a clinically controlled research setting*
GCC	*Gulf Cooperation Council countries, Saudi Arabia, UAE, Kuwait, Oman, Bahrain and Qatar.*
Healthcare provider	*A health care professional, facility or organisation licensed to provide healthcare services in the country in which it is located.*

DEFINITIONS

Terms	Definitions
Home nursing	*Visits from a qualified nurse to the patient's home to give expert nursing services:* • *Immediately after healthcare provider's treatment for as long as required by medical necessity.* • *Visits for as long as required by medical necessity for treatment which would normally be provided by a healthcare provider. In either case, the specialist who treated the patient must have recommended these services.*
Injury	*Injury is damage to the body caused by external force.*
In-patient	*A patient who stays overnight in healthcare provider while undergoing treatment.*
Insurer	*Saudi Arabian Insurance Company B.S.C. (c)*
Maternity benefit	*All aspects of pregnancy or childbirth, including pre and post-natal visits, check-ups, any complications and delivery, for any eligible female covered under the plan, but excluding:* • *treatment by way of the intentional termination of pregnancy unless two medical practitioners certify in writing that the pregnancy would endanger the life or mental stability of the mother and as permitted by the applicable law; and* • *treatment by way of nursery care for a dependent in a healthcare provider following childbirth, unless due to medical necessity during treatment that is otherwise covered by this policy.*

Terms	Definitions
Medical necessity	*Healthcare services and supplies which are determined by the company to be medically appropriate, and* • *necessary to meet the basic health needs of the Covered Person.* • *rendered in the most medically appropriate manner and type of setting appropriate for the delivery of the health service, taking into account both cost and quality of care* • *consistent in type, frequency and duration of treatment with scientifically based guidelines of medical, research, or healthcare coverage organizations or governmental agencies that are accepted by the Company.* • *consistent with the diagnosis of the condition.* • *required for reasons other than the convenience of the covered person or his or her physician.* • *demonstrated through prevailing pre-reviewed medical literature to be either:* 1. *safe and effective for treating or diagnosing the condition or sickness for which their use is proposed or,* 2. *safe with promising efficacy a) for treating a life threatening sickness or condition, b) in a clinically controlled research setting* *The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean that it is a medically necessary covered health service as defined in this policy. The definition of medically necessary used in this policy relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.*
Medical practitioner	*A doctor or specialist who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the treatment is provided.*
Medicine	*Pharmaceuticals authorized in the local country of prescription, which can only be obtained through a prescription written by a medical practitioner.*
Operation	*Any procedure described as an operation in the schedule of surgical procedures.*
Out-patient Services	*Services offered under this Policy such as Physician consultation, prescribed medicines, physiotherapy, diagnostic tests and treatment which are conducted on an Out-of-Hospital basis without jeopardising the Beneficiary's health or which do not require hospitalisation/ Day Care or necessitate specialised medical attention and care in a Medical Facility before, during or after the delivery*
Patient	*Employee or dependent who undergoes treatment.*
Plan	*The benefits that the insurer agreed to offer and accepted by the client.*

DEFINITIONS

Terms	Definitions
Policy	*The policy sent to the client comprising these policy terms, the policy schedule, list of benefits, and premium schedule.*
Policy schedule	*The policy schedule issued with the policy including any endorsements to it.*
Pre-admission certification	*A review and an initial decision by insurer or its third party administrator, before admission to the healthcare provider whether it is for an in-patient or day care treatment.*
Previous illness (pre-existing)	*Any bodily injury or illness or its related condition that is medically existing prior to the enrolment date of the insured member, whether it is known or not known to the member and necessitates the covered person to receive care and treatment.*
Pre-authorization	*A process through which a patient or designated healthcare provider seeks approval from insurer prior to undergoing treatment to ensure that the proposed treatment falls within the scope of cover, subject to the policy terms and conditions and shall fall within the healthcare providers agreed rates.*
Primary healthcare costs	*Costs in relation to medical practitioners fees', prescribed medicine/drugs, dressings, and dental emergency treatment in accordance and up to the limits detailed in the list of benefits.*
Private ambulance	*A purpose-built vehicle operated as an ambulance by a recognized private ambulance service or the private hospitals ambulance service.*
Qualified nurse	*A nurse who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided.*
Selected area of coverage	*The area available within your table of benefits provided by your employer. As selected by the client or the employer on the start date of the plan. 'Selected area of coverage' shall not include locations or coverage where applicable laws prohibit the insurance provided by the policy and/or related services and/or related payments.*
Short-term treatment	*Means a period of time consistent with the recuperation time required for the treatment and as prescribed by the treating medical practitioner with the approval of the insurer.*
Sickness	*A physical or mental illness*
Specialist	*A doctor who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided*

Terms	Definitions
Start date	*The date the policy starts, as shown in the policy schedule or the date you are enrolled under your company's group healthcare plan.*
Spouse	*Employee's wife or husband by legal marriage as advised to insurer. If the employee becomes divorced, cover for the spouse will end on the last day of the month in which the final decree of divorce has been granted. Cover for a partner other than a spouse must be agreed in writing between insurer and the client when the employee joins the plan.*
Subrogation	*The right for an insurer to pursue a third party that caused an insurance loss to the patient. This is done as a means of recovering the amount of the claim paid to the patient for the loss.*
Treatment	*Any relevant treatment controlled by a medical practitioner to cure or substantially relieve acute or chronic conditions within the scope of the plan.*
Undeclared pre-existing condition	*Any pre-existing condition known to the covered person or policyholder, which is not declared on the medical questionnaire or policy application.*
Vision benefit	*Procedures and treatment relating to the vision of an employee or dependent.*
Year of insurance	*The annual period starting on the start date or annual renewal date.*

IN CASE OF EMERGENCY

We understand that in an emergency you may not have time to contact us for pre-authorization. In such circumstances, we expect you to contact us only if you can and it is safe to do so. If it is not, and you need immediate treatment, please make that your priority without losing time.

However, please ask the provider to contact us within 24 hours of admission. Our authorization should be given before you are discharged from care, otherwise you may be required to pay the entire cost of your treatment and submit a reimbursement claim to SAICOHEALTH.

FINDING YOUR HEALTHCARE PROVIDER WITHIN YOUR NETWORK

Your medical policy network list includes a number of hospitals, clinics, pharmacies and other healthcare providers and centers within your region.

To find all your healthcare providers available within your network, access SAICOHEALTH Connect through the following link: **https://health.damana.com** or download **SAICOHEALTH Connect app,** available on Apple store and Google Play.

DIRECT BILLING

Direct billing is available for SAICOHEALTH members to avail health services in accordance with the insurance policy and/or schedule of benefits from a healthcare provider without making the full payment of charges to the healthcare provider.

The payment of charges for the health services incurred by you is directly paid by SAICOHEALTH to the healthcare provider. Where applicable, the member is responsible to pay any applicable deductible and co-insurance/co-pay directly to the healthcare provider.

Direct billing is available only in the designated healthcare providers listed by SAICOHEALTH in the network panel assigned for your policy.

- **Treatment within your network**
  When receiving treatment at any healthcare provider within your network, you are required to present your medical card or medical digital card to the healthcare provider along with your ID. If you do not present your medical card or ID at the time of visit to the healthcare provider, they may refuse to give treatment on direct billing basis.

- **Treatment outside your network**
  If you are eligible for reimbursement, then you can go to a non-network healthcare provider for your health service. However, you have to make the full payment of charges to the healthcare provider for the health services availed. To submit the claim on reimbursement basis please refer to page 18, ”Claims Reimbursement” section.

MSH International Overseas Direct Billing Services

Your healthcare insurance plan may include a direct billing service from MSH International (please check your table of benefits). MSH International connects eligible SAICOHEALTH members with the best quality healthcare services delivered through an international network. Through this service, members will access the best quality healthcare services delivered through an international network, without worrying to pay for the treatment in over 180 countries. All eligible members will have access to approximately 6,700 accredited providers for in-patient services direct billing and further support by 600,000 including United States, United Kingdom, Brazil, and Africa through other partnerships. Out-patient direct billing is also available worldwide in certain territories.

Important: Eligible claims incurred outside MSH network will be reimbursed subject to policy terms & conditions. All reimbursement claims need to be submitted to SAICOHEALTH.

How you will avail the services?

MSH are just a phone call away to help you with a wide array of unexpected medical conditions that can happen while travelling or on a business trip.

- When in need of medical assistance, check your medical card for your eligibility for MSH International.
- Call **24/7** active local number: **+971 4 365 1340**.
- Phone assistance is provided by multicultural/multi lingual team backed by a team of consulting physicians with personalized administration.
- Follow the instructions provided over the phone.
- Receive medical assistance as per treatment recommended and as covered by policy terms & conditions.
- Sign the healthcare provider claim document, from whom treatment was received.
- Settle directly any deductible and/or co-insurance share as indicated at the back of your medical card.
- Once you avail the services, the healthcare provider will co-ordinate with MSH International for rest of the formalities.

"MSH tools to help members search for healthcare providers worldwide."

In case you wish to confirm if a particular hospital is in the MSH network, you can **call +971 4 365 1335**, or login into the MSH portal **http://mena.msh-intl.com** or view it on the MSH mobile app. You can also conveniently search for nearby hospitals with the MSH mobile application. Online portal:

- Access a database listing healthcare providers across the globe.
- Login credentials will be sent on your registered email.
- Geo-locate nearby healthcare professionals wherever you are in the world.
- Plan medical appointments using the health directory available on the MSH INTERNATIONAL app.

PRE-AUTHORIZATION

Pre-authorization helps us assess each case and monitor the healthcare providers to make sure they provided you with the best care and treatment.

Below are the services that require pre-authorization:

- All in-patient benefits listed *(where you need to stay overnight in a hospital)*
- All day-care services
- Any out-patient visit where the net amount of claim is above **AED750/OMR79/BHR77/KWD61/QAR743** *(excluding consultation fee & medication price)*. Applicable to all specialties and all services.
- MRI, CT, PET scans
- Medications more than 3 months or above **AED750/OMR79/BHR77/KWD61/QAR743,** within the validity of the policy
- Vitamins prescribed by the doctor and medically justified
- Maternity and new born care:
  - First maternity visit to confirm pregnancy
  - Newborn care after delivery *(coverage under mother's medical card up to 30 days)*
- Physiotherapy
- Occupational therapy and rehabilitation
- Dental treatment including dental consultation and prescribed medication
- Optical benefits
- Alternative medicine treatment
- Home nursing
- Long-term care
- Psychiatric treatment
- Screening tests including routine adult physical, exams, pap smear, prostate cancer screening, mammograms for breast cancer screening
- Vaccines
- Devices like glucometers etc.
- Infertility/sterility
- Medical evacuation or repatriation including expenses for one person accompanying an evacuated/ repatriated person
- Services under 'benefits with a sub-limit'

For physiotherapy, the service should be requested by a specialized physician in specialties, like orthopedics, neurology, sports medicine, physical medicine, along with the signature and stamp of the treating physician. The physiotherapist can request extension or continuation of additional physiotherapy sessions *(should complete the full course of sessions advised by the physician).*

For optical benefit, the prescription for the refraction test and the lens and frame has to come from the treating ophthalmologist. The refraction test report and the lens prescription is to be signed and stamped by the treating ophthalmologist.

**Medical treatments at the designated medical providers, that require pre-authorization is the responsibility of the designated provider. Any medical treatment outside the designated providers' network, the member is responsible to obtain the pre-authorization from us for emergency or non-emergency conditions*

CLAIMS REIMBURSEMENT

If your treatment takes place within your designated network, SAICOHEALTH settles the invoices directly to the healthcare provider. Please ensure you present your medical card at the time of receiving treatment. You only need to pay any applicable co-insurance/deductible and cost of any ineligible treatment to the provider at the time of receiving treatment (if applicable to your plan).
In case you did not avail direct billing, your reimbursement will follow the same terms and conditions of out of network.

If your treatment takes place outside your designated network or for emergency in-patient treatment outside your country of residence, you will need to pay the provider all the expenses related to your medical treatment and then submit your claim form. Your claim form should be duly filled, stamped and signed by the treating doctor along with other supporting documents.

Note: All members are required to edit their profile on SAICOHEALTH Connect and add their mobile numbers, email addresses and bank information for automated reimbursement.

What should you submit?

You will have to submit at all times a filled, signed and stamped claim form with the following:

For In-patient Treatment:

- Duly completed claims form with stamp and signature of treating doctor.
- Itemized hospital bill supported by the official hospital receipt for the total amount paid.
- Copy of pathology/radiology investigation results
- Official receipt showing attending physician's or surgeon's charges along with his stamp & signature.
- Detailed hospital discharge report/medical report and operative notes.
- Copy of our pre-approval (if applicable)
- Copy of your medical card

For Out-patient Treatment:

- Duly completed claims form with sign and signature of treating doctor
- Official receipt showing the attending physician's detailed charges along with his stamp and signature.
- Itemized pharmacy bill showing the date of purchase, name of patient, quantity and name of drugs along with the physician's prescription.
- Official receipt showing charges for each of the lab test, X-ray films and other examinations done and supported by the respective physician's request to undergo examinations and copies of the results of examinations undertaken.
- You may refer to our detailed checklist for further information.

CLAIMS REIMBURSEMENT

Physiotherapy Treatments

- Treatments must be submitted with breakdown of sessions with dates
- Physiotherapy & chiropractic sessions must be prescribed by a specialist (e.g. orthopedic) in the relevant specialty & not by (1) GP or (2) Physiotherapist or (3) Chiropractic practitioner
- Extension of sessions based on the

Dental Claims

- Tooth No. required for services that are related to filling (No. of Surfaces), RCT, extraction
- Digital x-ray report for each & every RCT &/or Surgical extraction treatment

Optical Claims - (1) refraction test & (2) lens prescription

- Documents must be signed & stamped by an ophthalmologist & not an optometrist unless otherwise stated by the policy table of benefit

Chronic/Pre-existing Conditions

- For medicine, we need at least 1 year recent doctor prescription

How should you submit your Claims?

Claims must be scanned clearly & submitted through:

- SAICOHEALTH CONNECT mobile app or online portal
- **customerservice@saicohealth.com**

Claims must be submitted within:

- 60 days from service date, if claim incurred in member's territory
- 90 days from service date, if claim incurred outside member's territory

Important note:

If your employer has authorized an insurance broker to handle your healthcare plan with us, we do release the following information, if requested by the broker, about you and your dependents' claims:

- *who the claim was paid to*
- *when the claim was paid*
- *which payment method was used to pay the claim*

We do not release medical information about you and your dependents to the broker

COMPLAINTS HANDLING PROCEDURE

Visit our website to check out our complaints handling procedures on the following link:
https://www.damana.com/damana-complaints-procedures/

If you have a complaint regarding our practices and/or performance, which you are unable to resolve to your satisfaction with the account executive(s) whom we have assigned to manage your account, please visit:

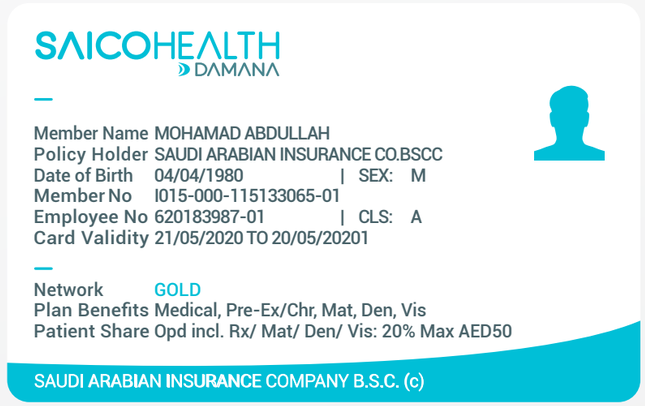
UAE:
https://complaints-uae.damana.com/

BAHRAIN:
https://complaints-bah.damana.com/

Kuwait:
https://complaints-kwt.damana.com/

Oman:
https://complaints-omn.damana.com/

MEDICAL CARD



1. **Member Name:** member full name
2. **Policyholder:** employer name
3. **Member No.:** includes the policy number & member number
4. **Employee No.:** family reference number
5. **Card Validity:** coverage start & end date
6. **Network:** name of designated healthcare provider list
7. **Plan Benefits:** covered benefits
8. **Patient Share:** fixed amount and % for a covered service, paid by a patient to the provider
9. **PreEx:** pre-existing within sub limit
10. **CHR:** chronic with sub limit
11. **Rx:** pharmaceutical co share with limit
12. **Mat. OP:** maternity outpatient share with maximum limit
13. **Dental:** dental cover
14. **Vis:** vision & optical cover

ASSIST AMERICA

GLOBAL EMERGENCY ASSISTANCE

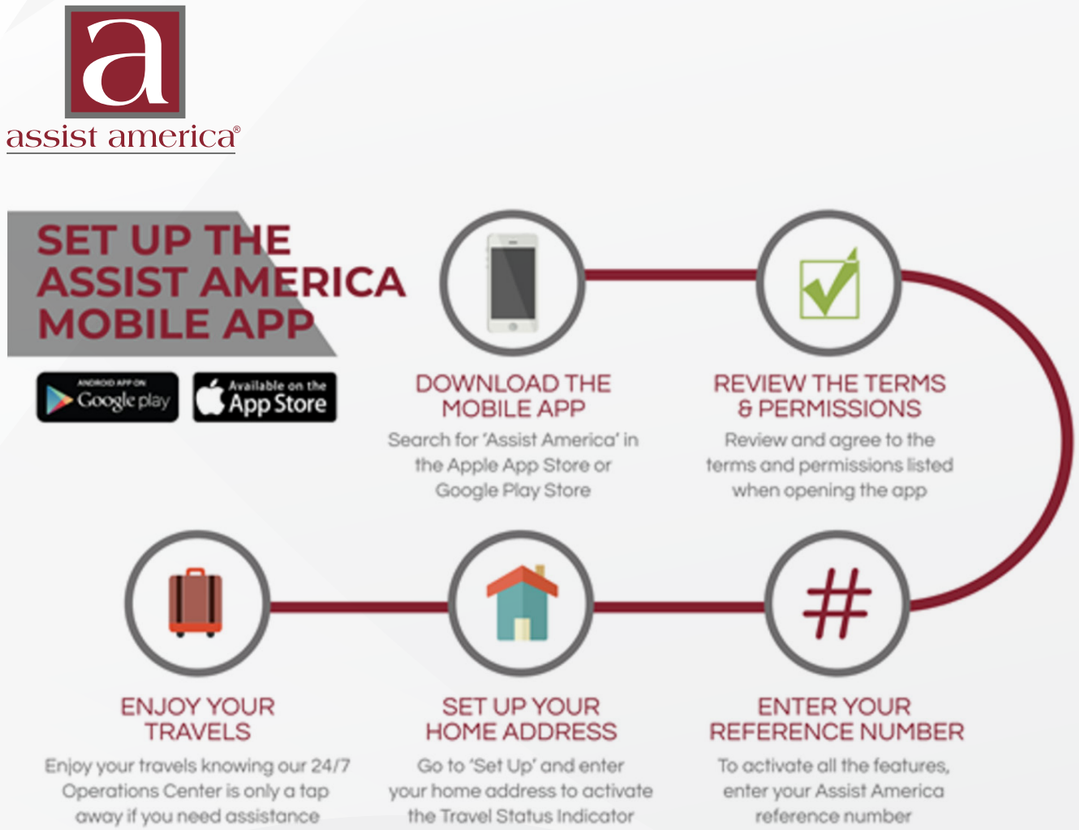
Assist America® provides global emergency assistance services for SAICOHEALTH members. If someone becomes ill or injured while traveling more than 150 kilometers away from home or is in a foreign country, Assist America provides support with medical referrals, monitoring, evacuation, repatriation and many other travel assistance services. Members can get help whenever they need it by downloading the Assist America Mobile App for iPhone and Android and pressing “Help” or by calling Assist America’s 7/24 Operations Center using the contact information and reference number on their Assist America membership card.

Assist America contacts:

- 1-877-488-9857 *(Toll Free – within the U.S.)*
- +1-609-275-4999
- VOIP *(Voice over Internet Protocol)* using WIFI connections
- Email: medservices@assistamerica.com

For more information, visit **www.assistamerica.com**

Note: *You can find your designated reference number on the back of your medical card.*



SAICOHEALTH CONNECT MOBILE APP & WEB PORTAL

With SAICOHEALTH Connect, you can:

- Check the policy benefits
- Review your approvals
- Check your claims statuses
- Search for healthcare providers
- Update your profile (email, mobile number, bank information)

Note: *All members are required to edit their profile on SAICOHEALTH Connect and add their mobile numbers, email addresses and bank information for automated reimbursement.*

Register on SAICOHEALTH Connect to access your account and benefit from all the features on **health.damana.com** or download the SAICOHEALTH Connect mobile app available on:

Download on the App Store

ANDROID APP ON Google play

CONTACT US

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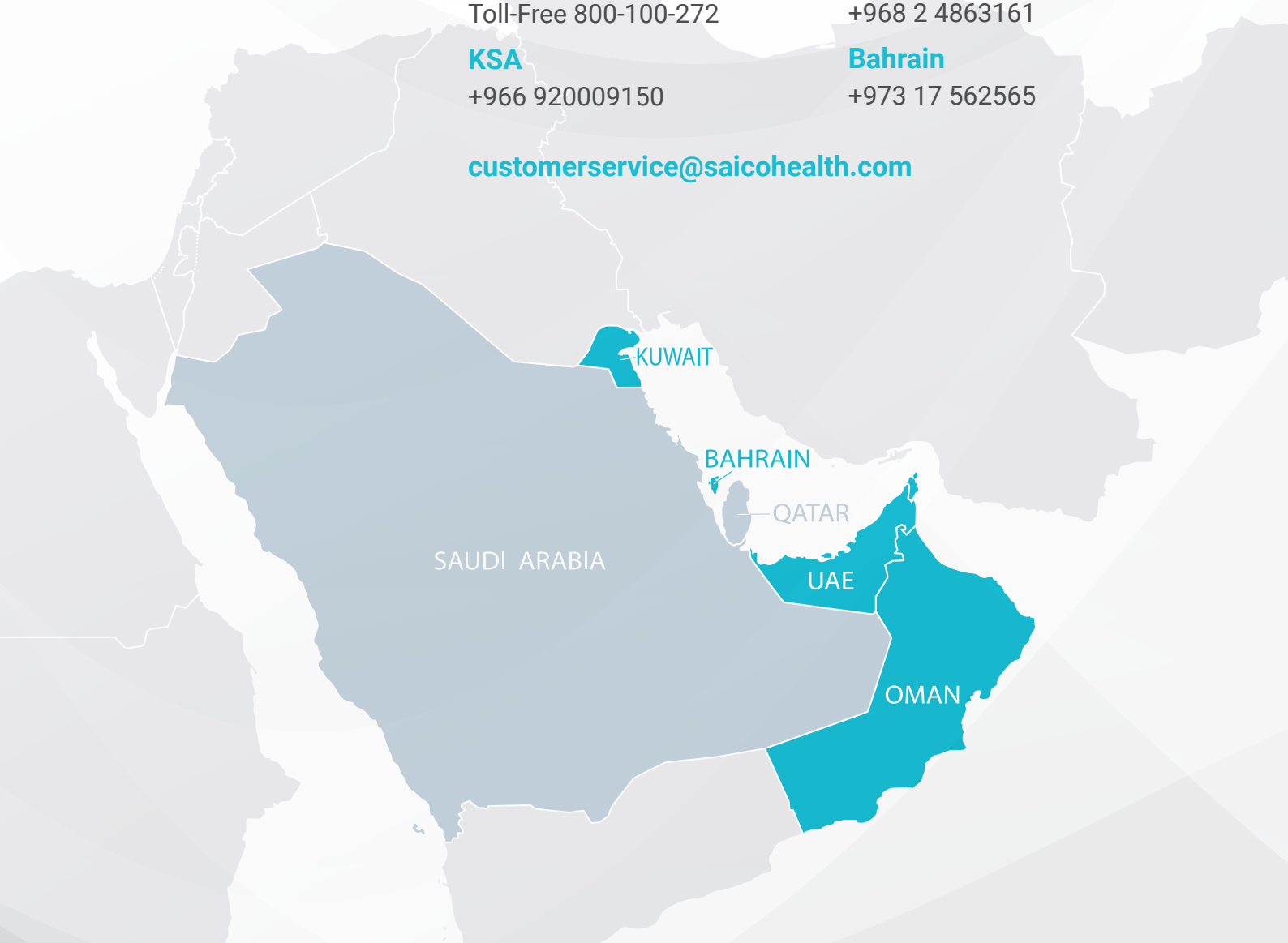

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